MEDI-CAL UPDATE

Outpatient Services
Bulletin 351

Billing and Policy
Clinics and Hospitals Bulletin 351 — January 2004

Contents

Articles with related Part 1 Manual Replacement Pages may be found in the "Program and Eligibility" bulletin. Articles with related Part 2 Manual Replacement Pages may be found in the "Billing and Policy" bulletin. The Medi-Cal Update *may not always contain a "Billing and Policy" section.*

Ibritumomab Tiuxetan (Zevalin): New Benefit

Effective for dates of service on or after April 1, 2004, Medi-Cal reimburses Yttrium-90 (Y-90) ibritumomab tiuxetan (Zevalin) injection (HCPCS code X7660) and Indium-111 (In-111) ibritumomab tiuxetan (HCPCS code X7662) when used to treat patients with relapsed or refractory low-grade follicular, or transformed B-cell non-Hodgkin's lymphoma refractory to treatment with rituximab 100 mg injection (HCPCS code X7634). The use of ibritumomab tiuxetan is subject to prior authorization and is limited to a maximum Units/Visits/Studies (U/V/S) of one unit for each code when billed by the same provider, for the same recipient and date of service.

Imaging and Therapy Protocol

Providers may be reimbursed for In-111 ibritumomab tiuxetan (HCPCS code X7662) and Y-90 ibritumomab tiuxetan (HCPCS code X7660) when treatment is administered under the following schedule:

Day 1: Imaging

- I.V. infusion of 250 mg/m² of rituximab (X7634)
- Within four hours – I.V. injection of In-111 ibritumomab tiuxetan (X7662) over a period of 10 minutes

Assessment of biodistribution:

- 1st image – 2 to 24 hours after injection of In-111 ibritumomab tiuxetan (X7662)
- 2nd image – 48 to 72 hours after injection of In-111 ibritumomab tiuxetan (X7662)
- 3rd image – 90 to 120 hours after injection of In-111 ibritumomab tiuxetan (X7662) (optional)

Days 7 – 9: Therapy

- I.V. infusion of 250 mg/m² of rituximab (X7634)
- Within four hours – I.V. injection of Y-90 ibritumomab tiuxetan (X7660) over a period of 10 minutes, not to exceed 32 mCi
  - 0.4 mCi/kg for patients with normal platelet counts
  - 0.3 mCi/kg for patients with platelet count of 100,000 – 149,000 cells/mm³

Please see **Ibritumomab**, *page 2*

Ibritumomab *(continued)*

Billing Requirements

Imaging Sequence

1. Rituximab 250 mg/m² (X7634) may be billed with CPT-4 code 96410 (chemotherapy administration, intravenous; infusion technique, up to one hour) and 96412 (…infusion technique, one to 8 hours, each additional hour).
2. In-111 ibritumomab tiuxetan (X7662) must be billed "By Report" with an attached copy of the manufacturer's (Zevalin) invoice and a description (including the name of the medication and dosage administered) entered in the *Remarks* area of the claim or on an attachment. Failure to submit the invoice with the claim will result in the claim being denied.
3. CPT-4 code 78802 (radiopharmaceutical localization of tumor; whole body) may be billed per scan to a maximum of three.

Therapy Protocol

1. Rituximab 250 mg/m² (X7634) may be billed with CPT-4 codes 96410 and 96412.
2. Y-90 ibritumomab tiuxetan (X7660) may be billed with CPT-4 codes 77750 (infusion or instillation of radioelement solution) and 77790 (supervision, handling, loading of radiation source) and should be billed "By Report" with an attached copy of the manufacturer's invoice and a description (including the name of the medication and dosage administered) entered in the *Remarks* area of the claim or on an attachment. Failure to submit the invoice with the claim will result in the claim being denied.

Prior Authorization

A *Treatment Authorization Request* (TAR) is required for treatment with Y-90 ibritumomab tiuxetan (X7660) and In-111 ibritumomab tiuxetan (X7662) and must include the following:

- A pathological report of a low-grade follicular or transformed B-cell non-Hodgkin's lymphoma
- Documentation that the recipient has undergone a chemotherapy regimen that included rituximab (X7634) and that the lymphoma was refractory or became refractory to the chemotherapy regimen; and
- Documentation that the platelet count of the recipient is not less than 100,000 cells/mm³.

The updated information is reflected on manual replacement pages chemo 14 and 15 (Part 2).

End Stage Renal Dialysis: Prior Authorization Update

Effective February 1, 2004, the following End Stage Renal Dialysis (ESRD) treatment codes no longer require prior authorization:

HCPCS Code	Description
Z6000	Maintenance dialysis including professional charges and routine laboratory services
Z6002	Maintenance dialysis including professional charges
Z6004	Maintenance dialysis including routine laboratory charges
Z6006	Maintenance dialysis only

Please see **Dialysis**, *page 3*

Dialysis *(continued)*

HCPCS Code	Description
Z6008	Home training dialysis including professional charges and routine laboratory services
Z6010	Home training dialysis including professional charges
Z6012	Home training dialysis including routine laboratory charges
Z6014	Home training dialysis only

Centers for Medicare & Medicaid Services Exception Codes

HCPCS Code	Description
Z6016	Maintenance dialysis including professional charges and routine laboratory services (CMS approved)
Z6018	Maintenance dialysis including professional charges (CMS approved)
Z6020	Maintenance dialysis including routine laboratory services (CMS approved)
Z6022	Maintenance dialysis only (CMS approved)
Z6036	Home training dialysis including professional charges and routine laboratory services (CMS approved)
Z6038	Home training dialysis including professional charges (CMS approved)
Z6040	Home training dialysis including routine laboratory charges (CMS approved)
Z6042	Home training dialysis only (CMS approved)

Support Services

HCPCS Code	Description
Z6030	Home dialysis (peritoneal or hemodialysis), including laboratory, support services, routine injections, and home dialysis supplies on a monthly basis
Z6032	Installation charge for home dialysis
Z6034	Repair and service for home dialysis

The updated information is reflected on manual replacement page dial end 2 (Part 2).

Travel for Collection of Lab Specimens: Benefit Deletion

Effective for dates of service on or after February 1, 2004, traveling for the sole purpose of drawing blood specimens outside a physician's office, laboratory or hospital setting from a recipient who is homebound or at a nursing facility (HCPCS code X0800) is no longer a Medi-Cal benefit and will no longer be reimbursed.

Organized Outpatient Clinics: Service Limitations

Organized outpatient clinics exempt from licensure based on *Health and Safety Code*, Section 1206, may only bill the following CPT-4 codes for Magnetic Resonance Imaging (MRI):

70540	70553	72146	72157	73218	73718	73723
70542	71550	72147	72158	73219	73719	74181
70543	71551	72148	72195	73220	73720	74183
70551	71552	72149	72196	73222	73721	76093
70552	72141	72156	72197	73223	73722	76094

These services require a *Treatment Authorization Request* (TAR).

Note: Affected clinics will be notified in a provider letter with the effective date of this policy.

This information is reflected on manual replacement page radi dia 15 (Part 2).

Transplant Services: Billing Update

In order to avoid confusion and improve accurate payment, effective February 1, 2004, transplant recipient and donor services always must be billed on separate claims. If there are multiple donors, separate claims are required for each donor. This is not a change to transplant policy but is a change to billing practices. In addition, documentation requirements for transplant claims are updated as shown in the following chart.

Claim Field	Enter for Transplant Recipient	Enter for Transplant Donor
Patient Name (Box 12 on *UB-92*)	Recipient's name	Donor's name
Birthdate (Box 14 on *UB-92*)	Recipient's birthdate	Recipient's birthdate
Sex (Box 15 on *UB-92*)	Recipient's sex	Recipient's sex
Medi-Cal Identification Number (Box 60 on *UB-92*)	Recipient's ID number	Recipient's ID number
Patient's Relationship to Insured field (Box 59 on *UB-92*)		11 (this is a code describing that the claim is for the donor)
Documentation (Box 84 on *UB-92*)	Transplant recipient	(Name of) transplant donor for (name of transplant recipient). Number of donors (for example, 1 of 1 or 1 of 2).

Please refer to manual replacement pages transplant 5 and 7 (Part 2).

Other Contraceptive Supplies: Billing Example

The *Family Planning Billing Example: UB-92* section has been added to help providers complete claims when billing HCPCS code X1500 (other contraceptive supplies). *Please refer to new manual pages fam planning ub 1 thru 3 (Part 2).*

Use of Modifiers: Billing Reminder

Providers are reminded that up to four modifiers may be entered on outpatient UB-92 claims. Modifiers one and two must be entered immediately following the HCPCS code in the *HCPCS/Rates* field (Box 44) with no spaces. The remaining two modifiers are entered in Box 49 with no spaces. This information appears in the *UB-92 Completion: Outpatient Services* section of the Part 2 manual.

Laparoscopy Rate Adjustment for Assistant Surgeons

A pricing error has been identified on assistant surgeon claims billed for CPT-4 code 47564 (other laparoscopy, surgical; cholecystectomy with exploration of common duct). Claims submitted for dates of service on or after October 30, 2000 for this procedure will be automatically reprocessed, resulting in an increased payment.

Billing Correction: Hypercalcemia of Malignancy

The *Injections* section of the provider manual has been updated to correctly reflect that one of the ICD-9-CM diagnosis codes that may be billed with pamidronate is code 275.42 (hypercalcemia). The manual incorrectly listed 275.4 (disorders of calcium metabolism), which was phased out in 1997. An Erroneous Payment Correction (EPC) is being generated to adjust affected claims for dates of service on or after October 1, 1997.

This change is reflected on manual replacement page inject 33 (Part 2).

Cancer Detection Programs: Every Woman Counts Claim Submission Reminder

Cancer Detection Programs: Every Woman Counts claims can be submitted either hard copy or electronically using the *UB-92 Claim Form*. Providers who choose to submit hard copy claims must send claims to the following address:

EDS
P. O. Box 15600
Sacramento, CA 95852-1600

Claims submitted to the wrong address will be forwarded appropriately, but processing will be delayed. To order pre-addressed envelopes for claim submission (thereby ensuring that claims are sent to the correct address), refer to the appropriate Forms Reorder Request section of the Part 2 manual or call the Provider Support Center (PSC) at 1-800-541-5555. For more information about claim submission requirements, refer to the *UB-92 Submission and Timeliness Instructions* section of the Part 2 manual.

This information is reflected on manual replacement page can detect 22 (Part 2).

San Diego Medi-Cal Field Office Address and Telephone Changes

Effective October 31, 2003, the address and telephone numbers for the San Diego Medi-Cal Field Office (SDMFO) changed as follows. All SDMFO *Treatment Authorization Requests* (TARs) should now be submitted to the new address.

San Diego Medi-Cal Field Office
9555 Chesapeake Drive, Suite 203
San Diego, CA 92123-6394

(619) 688-4204
Toll-free fax: 1-888-899-2505

The post office box remains the same:

P.O. Box 85344
San Diego, CA 92186-5344

This information is reflected on provider manual replacement page tar field 8 (Part 2).

Indian Health Services: Reimbursement Rate Update

New calendar year 2003 reimbursement rates for services covered by the Indian Health Services Memorandum of Agreement (IHS/MOA) were recently published in the *Federal Register*. For claims with dates of service during the 2003 calendar year, Indian Health Services providers are reimbursed at an all-inclusive, per-visit rate of $206 per outpatient visit when billed with per-visit codes 01 – 04, 06 – 09, 11 – 18, 23 and 24. Per-visit code 05 is reimbursed at the current Medi-Cal rate of $393.

Participating IHS/MOA providers with claims for dates of service between January 1, 2003 and November 14, 2003 will receive notification, and these claims will be automatically reprocessed.

For more information, please refer to the following sections and forms in the Part 2 manual:

- *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics*
- *Indian Health Services (IHS), Memorandum of Agreement (MOA) 638, Clinics: Billing Codes*
- *"Elect to Participate" Indian Health Services Memorandum of Agreement (IHS/MOA) Application* (form DHS 7108)

Provider Orientation and Update Sessions

The Family PACT (Planning, Access, Care and Treatment) Program was established in January 1997 to expand access to comprehensive family planning services for low-income California residents.

To be eligible to enroll as a medical provider in the Family PACT Program, the Medi-Cal provider seeking enrollment is required to attend a Provider Orientation and Update Session. When a group provider wishes to enroll, a physician-owner must attend the session. When a clinic wishes to enroll, the medical director or clinician responsible for oversight of the medical services rendered in connection with the Medi-Cal provider number is required to attend.

Office staff members, such as clinic managers and receptionists, are encouraged to attend but are not eligible to receive a *Certificate of Attendance*. Currently enrolled clinicians and staff are encouraged to attend to remain up to date with program policies and services.

Note: Medi-Cal laboratory and pharmacy providers are automatically eligible to participate in the Family PACT Program without attending an orientation session.

Please see **Family Pact**, *page 7*

Family Pact *(continued)*

Dates and Locations

The following dates and locations are scheduled through April 2004:

February 24, 2004
Anaheim
Radisson Hotel Maingate
1850 South Harbor Boulevard
Anaheim, CA 92802
For directions, call
(714) 750-2801

March 9, 2004
Merced
Ramada Inn
2000 East Childs Avenue
Merced, CA 95340
For directions, call
(209) 723-3121

March 24, 2004
Bakersfield
Double Tree Hotel
3100 Camino Del Rio Court
Bakersfield, CA 93308
For directions, call
(661) 323-7111

April 21, 2004
Stockton
Courtyard by Marriott
3252 West March Lane
Stockton, CA 95219
For directions, call
(209) 472-9700

Check-in begins at 8 a.m. All orientation sessions start promptly at 8:30 a.m. and end by 4:30 p.m. The session covers Family PACT provider enrollment and responsibilities, client eligibility and enrollment, special scope of client services and benefits, provider resources and client education materials. This is not a billing seminar.

Provider Orientation and Update Session Registration

Providers should call the Center for Health Training at (510) 835-3795, ext. 113, to register for the session they plan to attend. Providers must supply the name of the Medi-Cal provider or facility, the Medi-Cal provider number, a contact telephone number, the anticipated number of people who will be attending and the location of the orientation session. At the session, providers must present their Medi-Cal provider number, medical license number and photo identification. Individuals representing a clinic or physician group should use the clinic or group Medi-Cal provider number, not the individual provider number or license number.

Completing Provider Orientation and Update Session

Upon completion of the orientation session, each prospective new Family PACT medical provider will be mailed a *Certificate of Attendance*. Providers should include the white copy of the *Certificate of Attendance* when submitting the Family PACT application and agreement forms (available at the session) to Provider Enrollment Services.

Providers arriving late or leaving early will not be mailed a *Certificate of Attendance*. Currently enrolled Family PACT providers will not receive a certificate.

Family PACT Contact Information

For more information regarding the Family PACT Program, please call the Provider Support Center (PSC) at 1-800-541-5555 from 8 a.m. to 5 p.m., Monday through Friday, except holidays, or visit the Family PACT Web site at **www.familypact.org**.

Part 2

Remove and replace:	can detect 21/22
Remove:	chemo 13 thru 22
Insert:	chemo 13 thru 24 *(new)*
Remove and replace:	dial chr 3/4 *, 7/8 *
Remove:	dial end 1 thru 4
Insert:	dial end 1 thru 5 *(new)*
Remove and replace:	dial ex ub 1 thru 4 * hcpcs iii 3/4 *
Insert new section after the end of the *Family Planning* section:	fam planning ub 1 thru 3 *(new)*
Remove and replace:	inject 33/34 inject list 1/2 *, 9/10 * modif used 3/4 *, 9/10 * non ph 11/12 * oth hlth 7/8 *
Remove:	path hema 3 thru 7
Insert:	path hema 3 thru 6 *
Remove and replace:	radi dia 15 thru 25 rates max lab 1/2 * tar field 7/8 transplant 5 thru 8 ub comp op 5/6* , 19/20*
Remove and replace at the end of the *UB-92 Completion: Outpatient Services* section:	*Code Correlation Guide* 1/2 *

* Pages updated/corrected due to ongoing provider manual revisions.